IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8972

August 3, 2006

Matthew Kent, Administrator
Idaho Falls Good Samaritan Center
840 East Elva Street
Idaho Falls, ID 83401

FILE COPY

Provider #: 135092

Dear Mr. Kent:

On July 26, 2006, a fire safety survey was conducted at Idaho Falls Good Samaritan Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be widespread deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 15, 2006**. Failure to submit an acceptable PoC by **August 15, 2006**, may result in the imposition of civil monetary penalties by **September 5, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 30, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 30, 2006**. A change in the seriousness of the deficiencies on **August 30, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 30, 2006** includes the following:

Denial of payment for new admissions effective **October 26, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 26, 2007**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW
3232 Elder Street

P.O. Box 83720
Boise, ID 83720-0036

If you choose and so indicate, the POC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 26, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR 488.331, you have the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 15, 2006**.

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

If your request for informal dispute resolution is received after **August 15, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

MARK P. GRIMES
Supervisor
Facility Fire Life Safety and Construction

MG/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135092	A. BUILDING 02 - ENTIRE STRUCTURE B. WING _____	07/26/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GOOD SAMARITAN CTR	840 E ELVA ST IDAHO FALLS, ID 83401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Fire / Life Safety Survey was conducted At Idaho Falls Good Samaritan Center on 7/26/2006. The 2000 Existing Edition of the Life Safety Code was utilized for this survey. The facility is a single story, Type V (111) construction with a partial basement. It has a composite pitched roof and multiple exits to grade. Original construction was June 1964 with an addition in 1985 and a major renovation in 1995. It is sprinklered and has smoke detection coverage in corridors and open spaces. Currently the facility is licensed for 113 beds. On the day of the survey they had a census of 64 residents. The deficiencies identified during this survey are listed below. The surveyors conducting the survey were: Debby Ransom, RN, RHIT, Bureau Chief Facility Standards Mark Grimes, Supervisor Facility Fire / Life Safety Program Taylor Barkley Health Facility Surveyor	K 000	RECEIVED AUG 17 2006 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Mark Canty | ADMINISTRATOR | 8/15/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5. 19.3.7.6. 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure that all doors in smoke barriers were self-closing and sealed against the passage of smoke. This deficient practice affected three of twelve smoke compartments. Findings include: 1. During the facility tour on 07/26/06 it was observed by the survey team and maintenance staff that the smoke doors by room 137 did not close and latch completely when released. 2. During the facility tour on 07/26/06 it was observed by the survey team and maintenance staff that the smoke doors by room 201 did not close and latch completely when released. 3. During the facility tour on 07/26/06 it was observed by the survey team and maintenance staff that the smoke doors by the activities room did not provide a smoke resistant barrier between the door edges. When closed, the doors had a	K 027	**K027** 1. Fire doors outside of rooms 137 and 201 were adjusted on 7/27/06. Doors now close properly. Smoke seal on Activities door was ordered on 8/4/06 and will be installed by 8/21/06. 2. All other fire doors were checked for proper closure on 7/27/06. 3. During the fire extinguisher inspection each month, each fire door will be inspected by Maintenance Director to ensure they close properly. 4. An audit will be conducted monthly by the QA Director for 3 months, and then quarterly for 6 months. Results will be reported to the QA Committee. 5. Compliance will be by 8/21/06.	

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K 027	Continued From page 2 gap of one finger width between the meeting edges. NFPA Standard: NFPA 101, Sect. 8.3.4.1 states that doors in smoke barriers shall completely close the opening leaving only the minimum clearance necessary for proper operation.	K 027		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the facility had not ensured compliance with requirements. The findings include: Observation on 7/26/2006, disclosed that the inspection tag, affixed to the riser for the sprinkler system, had been marked to show the last extinguishing system inspection had been	K 056	**K056** 1. Fire inspection was completed on 8/2/06 by contracted vendor. 2. No other areas are affected by this deficiency. 3. Maintenance Director will schedule the 2007 annual inspection in June 2007. 4. Administrator will ensure that the 2007 has been completed in July 2007, and report results to the QA Committee. 5. Compliance was on 8/2/06.	

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K 056	Continued From page 3 conducted in August 2004. Review of inspection records did validate the last inspection date as August, 2004. Maintenance staff stated on July 26, 2006 that the sprinkler servicing company had not conducted the annual service on the system.	K 056		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based upon surveyor observation and staff interviews made on 07/26/06, it was determined that the facility did not assure that exit access corridors are maintained free of obstructions for the full required width of the corridor. Findings included: Five of five exit access corridors in the facility were observed by survey team and maintenance staff to have patient lifts, and linen carts stored against the corridor walls. Staff interviews confirmed the storage of these items in corridors.	K 072	**K072** 1. Hallway was cleared of unused equipment on 7/26/06. 2. All hallways were inspected on 7/27/06 and cleared of unused equipment. 3. Employee in-service was conducted on 8/10/06 to educate staff on the importance of keeping hallways clear of obstructions. 4. QA Director will ensure that an audit are conducted weekly for 3 months, quarterly for 6 months if weekly compliance is substantiated, and report results to the QA Committee monthly. 5. Compliance will be by 8/21/06.	

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K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations it was determined that the facility failed to ensure compliance with electrical safety regulations. The facility had 113 beds with a census of 64. All residents and staff were effected. Findings included: Observation in the buisiness office on 7/26/06 revealed a powerstrip supplying power to two other power strips. The findings were observed by survey team and maintenance staff.	K 147	**K147** 1. Connection was removed on 7/27/06. 2. Offices were inspected by each responsible Department Head on 7/27/06 for further problems. 3. An in-service was held on 8/2/06 for department heads on the need to follow guidelines for electrical outlets. 4. Monthly preventative maintenance list will include an audit for two offices per month to be audited for 6 months to ensure that compliance is being maintained. Results will be reported to the QA Committee monthly for 6 months. 5. Compliance was on 8/21/06.	

PRINTED: 07/31/2006
FORM APPROVED

Bureau of Facility Standards

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. A Fire / Life Safety Survey was conducted At Idaho Falls Good Samaritan Center on 7/26/2006. The 1985 Existing Edition of the Life Safety Code was utilized for this survey. The facility is a single story, Type V (111) construction with a partial basement. It has a composite pitched roof and multiple exits to grade. Original construction was June 1964 with an addition in 1985 and a major renovation in 1995. It is sprinklered and has smoke detection coverage in corridors and open spaces. Currently the facility is licensed for 113 beds. On the day of the survey they had a census of 64 residents. The deficiencies identified during this survey are listed below. The surveyors conducting the survey were: Debby Ransom, RN, RHIT, Bureau Chief Facility Standards Mark Grimes, Supervisor Facility Fire / Life Safety Program Taylor Barkley Health Facility Surveyor	C 000		
C 230	02.106.02.b b. Existing facilities licensed prior to the effective date of these	C 230	REFER TO CMS 2567 FOR PLAN OF CORRECTION	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 8/15/06

STATE FORM 6899 I2ZV21 If continuation sheet 1 of 2

Bureau of Facility Standards

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C 230	Continued From page 1 rules, regulations and minimum standards and in compliance with a previous edition of the Life Safety Code may continue to comply with the edition in force at that time. This Rule is not met as evidenced by: * Refer to K027, K056, K072, K147 on the CMS - 2567.	C 230		